STATE OF VERMONT

HUMAN SERVICES BOARD

In re	)	Fair Hearing No. R-05/09-290
	)	
Appeal of	)	

INTRODUCTION

The petitioner appeals a decision by the Department for Children and Families, Economic Services Division, Health Access Eligibility Unit (HEAU) terminating her Vermont Health Access Plan (VHAP) benefits. The issue is whether the petitioner should have received continuing VHAP benefits during the pendency of this fair hearing. The following discussion is based on the written arguments and documents filed by the parties and on the representations of counsel during the telephone status conferences that have been held in the matter.

DISCUSSION

The petitioner has been receiving VHAP since 2006. Since 2008, her husband had also received VHAP. In April 2009 the petitioner submitted a recertification application to the Department. Prior to April 2009, based on the income she had reported on previous recertification applications, she and her husband had been receiving VHAP without having to pay a premium. Although it is not clear from the application

itself, and for reasons unexplained, the petitioner now maintains that she did not intend to include her husband in her April 2009 recertification application.

On May 8, 2009 the Department sent the petitioner a notice denying Medicaid and VHAP coverage for her and her husband, but finding them both eligible for Employer-Sponsored Insurance Assistance (ESIA), effective May 8, 2009. (The Department admits that it assumed that the petitioner's husband was included on her most recent application.) The basis for the Department's decision denying Medicaid was "you are not in the category of people who may receive Medicaid".[1] The reason given for denying VHAP was "your income is more than the rules allow". The portion of the notice regarding their eligibility for ESIA included the following (all emphasis in the original):

> **Important!** Even though you are eligible, you do not have a benefit until we have information about any health insurance plans offered by your employer or your spouse's employer. We need this information to determine which program you are eligible for. Within a few days, the OVHA-Coordination of Benefits Unit will send you a follow-up letter to gather information regarding health insurance plans that the employer offers. If the employer does not offer insurance, you may qualify for premium assistance for Catamount Health (CHAP). However, you must return the plan information request letter before we can consider your eligibility

[1] The notice listed the Medicaid categories of age, disability, and parents of minor children.

> for CHAP. **Do not enroll in any employer sponsored insurance until we ask you to!**
>
> This is a multi-step process. After they receive the employer insurance information from you, the OVHA-Coordination of Benefits Unit will send additional letters. Follow the instructions in the letters and call Member Services at 1-800-250-8427 if you have any questions.
>
> **Benefit**
>
> Premium Assistance program are for adults who are not eligible for the Vermont Health Access Plan (VHAP). The programs help pay for insurance through Catamount Health plans or an employer's health insurance plan.

On May 11, 2009, the Department sent the petitioner a Plan Information Request notice. The notice included the following (emphasis in original):

> You have until 5/23/2009 to send in the completed form. If you do not return the completed form, you will be denied Premium Assistance and, **if you have VHAP**, **coverage will end**.

On May 15, 2009 the Department sent the petitioner and her husband a Vermont Health Care Programs Bill. The premium amounts in the bill were $60 each for the petitioner and her husband. The bill included detailed instructions and deadlines for payment ("upon receipt"). It also included the following notice in bold type:

> We cannot pay for any services until this premium bill is paid. The sooner you pay, the sooner coverage

> begins. After we receive payment, we will send a letter telling you when coverage begins.

It is not clear whether the petitioner and/or her husband, or her husband's employer, returned the Plan Information Request form the Department had sent on May 11. However, on May 18, 2009 the Department sent the petitioner a Notice of Decision that it was "not requiring you to sign up for the employer's insurance at this time". The notice included the following (with original emphasis):

> You now have the option to enroll in CHAP. CHAP is a premium assistance program to purchase a Catamount Health policy.
> . . .
>
> **Important!** Even though you are eligible, you must pay a premium before you can get a benefit. After your premium has been paid we will send you information on choosing a Catamount Health plan. You will get a bill with payment instructions in the next few days. Your premium is due when you get the bill. The sooner the premium payment is made the sooner assistance can begin.
>
> **Premiums**
>
> A monthly premium is required. The premium amount is based on the information we have on file about your household income and size at the time the bill is generated.

On May 19, 2009 the petitioner requested an appeal through her district office regarding "denial of VHAP because over income". This appeal was received by the Board on May 26, 2009. On May 27, 2009 the Board mailed the petitioner

and the Department a notice scheduling the matter for a fair hearing on June 5, 2009. On June 3, 2009 the petitioner's attorney filed a notice of appearance with the Board by email and requested that the hearing be continued to allow her an "opportunity to review the file and the basis for denial". The Department did not oppose the continuance. On June 4, 2009 the Board notified the parties that it was scheduling the matter as a telephone status conference on July 10, 2009.

On June 19, 2009, the Department sent the petitioner a "Health Care Closure Notice" that her and her husband's health care coverage would end on June 30, 2009 "because we did not receive your premium as required". The petitioner did not respond to this notice. The Department terminated the petitioner's VHAP on June 30, 2009.

The hearing officer conducted a telephone status conference with the parties' respective attorneys on July 10, 2009. His notes from that conference and his recollection are that the petitioner's counsel informed him and the Department that there was a "notice issue" and that the dispute concerned the calculation of petitioner's income in light of "household size and room and board". The parties agreed that the petitioner's counsel would obtain more

information and "submit the case in writing". There is no indication that any issue regarding continuing benefits was raised at that time.

The Board then heard nothing from either party until September 16, when petitioner's counsel requested another status conference. Petitioner's counsel now represents that the delay was due to the Department being "non-responsive" to her requests for copies of premium bills it had sent the petitioner and her husband.

At any rate, another telephone status conference was held on October 9, 2009. The hearing officer's notes reflect that the parties informed him that the issues included the treatment of claimed business expense deductions, the inclusion of the petitioner's husband in the household, and the termination of continuing benefits due to the lack of premium payments. The parties agreed that the facts did not appear to be in dispute, and that they would file written arguments in the matter. Nothing in the hearing officer's notes or recollection of that status conference indicates that the petitioner communicated any timeliness concerns whatsoever regarding any issue, including the lack of continuing benefits.

On December 31, 2009, having heard nothing more from the parties after the October 9 status conference, the hearing officer sent the parties a memorandum giving the petitioner until January 29, 2010 to submit her written argument or face dismissal. On January 28, 2010, the petitioner submitted a Memorandum of Law. The Department filed a response on February 11, 2010.

In her memorandum the petitioner represents that her delay in filing her argument was the Department's failure to respond to her offer of stipulated facts. She now concedes, however, that as of the date of her recertification application on April 4, 2009 she was over the income maximum to qualify for VHAP. She also admits that she has not made any premium payments since that time, though she does not appear to dispute that the Department's determination of her eligibility for CHAP was correct, and that its calculations of her premiums were accurate based on her household income. Nonetheless she alleges that she has gone without health coverage since her VHAP was terminated on June 30, 2009. Her arguments at this time are that the Department's closure notices in May and June 2009 were insufficient and that her VHAP benefits should have continued pending the outcome of this hearing.

W.A.M. § provides:

> When beneficiaries appeal a decision to end or reduce VHAP coverage, they have the right, under certain conditions, to have benefits continue without change until the appeal or fair hearing is decided provided the beneficiary has requested an appeal before the effective date of the change and has paid in full any required premiums. . .

In this case the Board need not decide whether the above provision justified the Department's closure of her VHAP on June 30, 2009. The petitioner has been represented by counsel since at least June 3, 2009. The facts are clear and undisputed that several times both before and after that date, but well before the effective date of closure, the Department conspicuously and unequivocally warned the petitioner that her health care benefits would terminate on June 30, 2009 unless she paid the required premium.

As noted above, the petitioner does not now dispute that all of the Department's decisions were correct regarding both her eligibility for VHAP and the amount of any premium she would have to pay to become eligible for CHAP. All the notices that the petitioner now takes issue with were issued in May and June 2009. However, the procedural record in this case is clear that the petitioner essentially sat on her rights for seven months, did not pay any premiums, and did not vigorously prosecute the matter until the hearing officer

threatened her with dismissal. In light of this, she cannot now in good faith, and for the first time, attempt to blame the Department for the delays in the matter or argue that "due process" requires that she now be granted VHAP retroactively for a period in which she concedes she was not eligible.

Regardless of the merits to any procedural claims that the petitioner could, and should, have raised in a more timely manner, based on the above it must now be concluded that any retroactive relief in this matter is not "appropriate". See 3 V.S.A. § 3091(d).

ORDER

The Department's decision is affirmed.

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